MARKET CONDUCT EXAMINATION REPORT
Dated November 8, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2010 THROUGH JUNE 30, 2011

CIGNA HEALTHCARE OF COLORADO, INC
900 COTTAGE GROVE ROAD, C6ACC
HARTFORD, CT 06152

NAIC Company Code: 95604
NAIC Group Code: 0901

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

CIGNA HEALTHCARE OF COLORADO, INC
900 Cottage Grove Road, C6ACC
Hartford, CT 06152

MARKET CONDUCT EXAMINATION REPORT
DATED NOVEMBER 8, 2012

Covering the Time Period of January 1, 2010 through June 30, 2011

Examination Performed by:

State Market Conduct Examiner

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Examiner-in-Charge

And

Independent Contract Examiners

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COMPANY PROFILE

The following is based on information provided by Cigna HealthCare of Colorado, Inc., and has not been verified by the Colorado Division of Insurance:

Cigna HealthCare of Colorado, Inc. was incorporated in the State of Colorado as a for-profit corporation on November 20, 1985. The Company was issued a certificate of authority to operate as a health maintenance organization (HMO) by the Colorado Division of Insurance on May 16, 1986.

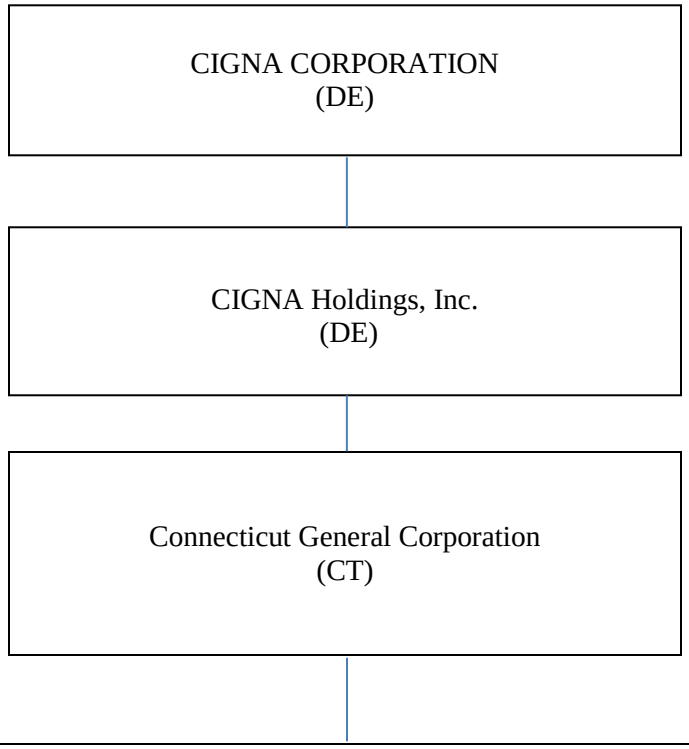
The Company was originally incorporated under the name of Cigna Healthplan of Colorado, Inc. On August 30, 1993, the corporate name was changed to Cigna HealthCare of Colorado, Inc. The Company was issued a certificate of authority with the new corporate name on October 28, 1993.

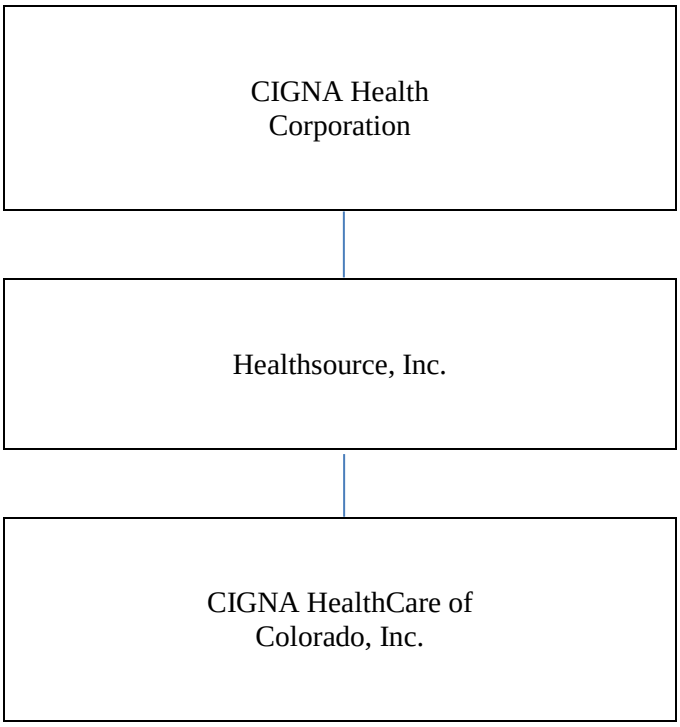
The Company is a wholly-owned subsidiary of Healthsource, Inc., which in turn is a wholly-owned subsidiary of Cigna Health Corporation, which in turn is a wholly-owned subsidiary of Connecticut General Corporation, which in turn is a wholly-owned subsidiary of Cigna Holdings, Inc., which in turn is a wholly-owned subsidiary of Cigna Corporation, a publicly-held corporation.

Cigna stopped selling or renewing small employer business on May 25, 2004 and any existing groups were cancelled beginning in January of 2005, i.e., it had no small group or individual coverage, other than conversion, for 2010 or as of January 1, 2011.

STRUCTURE AS OF OCTOBER 10, 2010

An abbreviated organizational chart depicting Cigna HealthCare's relationship with its ultimate controlling entity as of December 31, 2009 is depicted below:





Enrollment and Market Share as of December 31, 2010

Individual HMO Enrollment:	18 (Conversion Plans)
Large Group HMO Enrollment:	4,921
Large Group Point-of Service (POS) Enrollment:	603
Market Share (As a percentage of Colorado Total Accident and Health):	.52%*

Individual and Group A&H Written Premium*

Individual Written Premium as of 12/31/2010:	$312,000 (Conversion Plans)
Large Group Written Premium as of 12/31/2010:	$25,323,000

*As shown in the 2010 Edition of the Colorado Insurance Industry Statistical Report

PURPOSE AND SCOPE

A state market conduct examiner with the Colorado Division of Insurance ("Division"), who was assisted by independent contract examiners, reviewed certain business practices of Cigna HealthCare of Colorado, Inc., ("Cigna" or "Company"). This market conduct examination ("MCE") was performed in accordance with Colorado insurance laws, §§ 10-1-203, 10-1-204, 10-1-205, 10-3-1106, and 10-16-416, C.R.S., that empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance in the State of Colorado. All work product developed in producing this report is the sole property of the Division.

The purpose of the examination was to determine Cigna's compliance with Colorado insurance laws related to HMO's in Colorado. Examination information contained in this report should serve only this purpose, except as provided by law pursuant to §§ 10-1-204 and 10-1-205, C.R.S. The findings and conclusions, including the Final Agency Order, arising out of this examination shall be a public record.

Examiners conducted the examination in accordance with procedures developed by the Division which are based on model procedures developed by the National Association of Insurance Commissioners, ("NAIC"). They relied primarily on records and materials maintained and/or supplied by Cigna. This MCE covered the period from January 1, 2010, through December 31, 2010 and also included the period of January 1 – June 30, 2011 for certain specified areas to review new requirements for mandated benefits effective as of January 1, 2011.

The examination included review of the following areas:

Company Operations and Management
Complaints
Producers
Contract Forms
Rates
New Business Applications and Renewals
Cancellations, Non-Renewals, Declinations and Rescissions
Claims Handling
Utilization Review

The examination report is a report by exception. References to additional practices, procedures, or files that did not exceed the error tolerance levels recommended by the NAIC were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contained a section that permitted Cigna to submit written responses to the examiners' comments.

Examination findings may result in administrative action by the Division. The examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company, HMO or insurance product.

METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. The examiners reviewed all relevant statutes and regulations pertaining to health benefit plans.

Sampling Methodology

The examiners selected all files where a sample of a larger population was taken, on a random basis in accordance with the sampling methodology set forth in the 2011 NAIC Market Regulation Handbook ("Handbook").

An error tolerance level of seven percent (7%) for claims, and ten percent (10%) for other samples, was established per the Handbook to determine reportable exceptions.

An error tolerance level of plus or minus ten dollars ($10.00) was also allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, administrative, underwriting and claims guidelines/procedures, and timely cooperation with the examination process.

Producers

The licensing status of all active and terminated producers and other entities and individuals involved in Cigna HealthCare's business during the period of the examination was reviewed for compliance with the appropriate Colorado statutes and regulations.

Contract Forms

The examiners reviewed the following forms that were in use during 2010 and as of January 1, 2011 for compliance with mandated benefits and other statutory and regulatory requirements.

INDIVIDUAL CONVERSION PLANS

Form Name	Form Number
Colorado Basic HMO Conversion Plan without Specified Mandates	CO.ICA-BASIC-2008
Face Sheet to the Cigna HealthCare Conversion Agreement	CO.ICA-BASIC-2008 CHC-IFS94
Standard HMO Conversion Plan	CO.ICA-STANDARD-2008
Face Sheet to the Cigna HealthCare Conversion Agreement	CO.ICA-STANDARD-2008 CHC-IFS94

LARGE GROUP HEALTH PLANS

Cigna HealthCare Handbook and Group Service Agreement GSA
Used as evidence of coverage for the four (4) stand-alone products listed below:

(1) HMO1-HMO (referrals required to specialty care physicians)

(2) HMO4-HMO Open Access (no referrals required to specialty care physicians)

(3) CHA1-POS (In-network benefits underwritten by Cigna and referrals required to specialty care physicians. Out-of-network benefits underwritten by Company's affiliate, Connecticut General Life Insurance Company, through a trust)

(4) CHA4-POS Open Access (In-network benefits underwritten by Cigna and no referrals required to specialty care physicians. Out of-network benefits underwritten by Company's affiliate, Connecticut General Life Insurance Company, through a trust)

Form Name	Form Number
Schedule of Copayments	GSA-SOC CO-L

RIDERS

Form Name	Form Number
Supplemental Rider-Prescription Drugs	RX-MG-CO-F (10/10)

ENROLLMENT FORMS

Form Name	Form Number
Enrollment/Change Form – HMO and POS Medical Only This form was used for all of the Cigna HMO and POS products.	579556
Enrollment/Change Form (Consolidated) Medical w Other Products This form was used for all of the Cigna HMO and POS products as well as other non-Cigna products.	579557a
Conversion Enrollment Form & the Basic or Standard Election Form	816128a

Rates

Rate filings for HMO and POS plans in effect during 2010 and from January 1, 2011 to June 30, 2011 were requested and provided for review. The Company indicated it typically submits rate filings in the August/September timeframe with the intention that the proposed rating changes would be effective sometime in the first quarter of the following year. However, the timing of responses from various state insurance departments varies, so it had a mechanism that allows the Company to "switch on" the new rating methodology/factors once approval is granted. In the meantime many of its clients (especially larger groups) request proposals well in advance of the effective date of coverage. As a result; for a 3/1/2011 effective date Cigna may be generating rates in the 4th quarter of 2010 and at that time the 2011

rate filing may not yet have been approved by the Colorado DOI. In these instances, the Company would generate rates based upon the approved "2010" rate filing.

The examiners reviewed the rates charged in the samples of the files selected for both new and renewal business in the applications section of the examination.

It was noted during the review of renewal business for 2011 that a program titled "early renewal incentive" was being used in which concessions were applied to the rates for certain groups if they chose to renew with Cigna earlier in the rating process, prior to their renewal date, and committed to not taking the case out to bid with other carriers. This provision was not expressed in the group insurance contracts, nor was it reflected in the rates filed with the Division for use during the period of the examination.

New Business Applications and Renewals

Cigna provided a population of three (3) New Business Group Applications and a population of sixty (60) Renewal Business Group files for 2010. A population of two (2) New Business Group Applications and a population of forty-nine (49) Renewal Business Group files were provided for January 1, through June 30, 2011.

Cigna provided a population of twenty (20) New and Renewal Individual Business Files for 2010 and twelve (12) Individual New and Renewal Business Files in 2011. The files provided for 2010 consisted of two (2) new business files and eighteen (18) renewal business files. The files provided for 2011 consisted of only renewal business files.

The examiners reviewed the files described above for compliance with statutory requirements and contractual obligations.

Cancellations, Non-Renewals, Declinations and Rescissions

For the period of January 1, 2010 through December 31, 2010, the Company provided a population of fourteen (14) cancelled/non-renewed group files. Seven (7) of these files were voluntary (non-renewals), two (2) of these files were cancelled for non-payment and five (5) of the files renewed with an Open Access Plus Plan, offered by a Cigna company other than Cigna HealthCare of Colorado. This population was reviewed for compliance with statutory requirements and contractual obligations. There were no rescissions reflected for the examination period.

Cigna provided a population of three (3) groups that were declined during 2010; however, the declination date for one (1) of these was later determined to be outside the period of the examination and not included in the review.

The Company provided a population of seven (7) individual files that had been cancelled or non-renewed during 2010. Five (5) of these were voluntary (non-renewals) and two (2) were cancelled for non-payment.

Claims Handling

Cigna had an inter-company agreement that facilitates the provision of mental health and substance abuse services to the members of all affiliated Cigna health maintenance organizations (the Cigna HMOs). The agreement for provision of mental health and/or substance abuse services is between Cigna Health Corporation (CHC) on behalf of the Cigna HMOs and Cigna Behavioral Health, Inc. (CBH) on behalf of itself and its subsidiary and affiliated corporations (the CHC/CBH Agreement). Pursuant to the

CHC/CBH Agreement, CBH provided mental health and substance abuse services to the enrollees of the Cigna HMOs through its nationwide network of mental health and substance abuse providers, which forms a component of the provider network of each participating Cigna HMO. Also pursuant to the CHC/CBH Agreement, CBH handled first level appeals of participants and providers and performed the functions of claim payment administration, utilization management, quality management, participant rights and responsibilities and provider credentialing (collectively, the "CBH Delegated Functions). CHC and CBH had also executed certain standards for the performance of the CBH Delegated Functions, which incorporated National Committee for Quality Assurance (NCQA) requirements and was utilized in conjunction with the CHC/CBH Agreement (the Standards for Delegation). The CHC/CBH Agreement and the Standards for Delegation had been filed on behalf of all of the Cigna HMOs with the appropriate Departments of Insurance.

National Imaging Associates (NIA) is a radiology benefits manager owned by Magellan Health Services. Cigna contracted with NIA to manage high tech radiology services in several markets. As of June 30, 2011, NIA no longer performed these services for Cigna members within the State of Colorado.

NIA had performed the following services for Cigna members within the State of Colorado:

- Precertification of MRI, MRA, CT and PET scans for those individuals with the Personal Health Solutions Plus (PHS+) medical management model;
- Network contracting and management of radiology centers, including credentialing activities;
- Claims payment for all NIA-contracted facilities; and
- Claims payment for delegated Cigna facilities for HMO and Network products in capitated NIA markets.

Cigna maintained a dedicated team of employees for management of organ transplants which is called "Lifesource Team". Once a member was entered into case management for transplant services, the member was flagged in the system and the Lifesource processing team received all the member's claims through the transplant process. The Lifesource team was made up of Cigna employees who had specialized training in transplant claims.

Cigna had a number of physical locations for claim processing. When a new account is sold, it was assigned to a claim office. During the time frame of the examination, most accounts' claims were processed in either the Denison, TX or the Scranton, PA claim offices. During periods of high volume, claims may have been resource balanced with other offices including Bourbonnais, IL and Visalia, CA.

Cigna's late payment interest and penalties were calculated manually by a "Late Payment Interest" team.

The following four (4) samples, randomly selected using ACL ™ software, were reviewed for overall claim handling and accuracy of processing.

2010:

- One hundred claims from a population of 52,696 paid claims received in 2010.

- One hundred claims from a population of 2,722 denied claims received in 2010.

2011 (1/01/11 through 6/30/11):

- One hundred claims from a population of 24,106 paid claims received in 2011.
- One hundred claims from a population of 1,718 denied claims received in 2011.

An additional three (3) samples were reviewed to determine the Company's compliance with Colorado's prompt payment of claims law.

- One hundred electronically received claims from a population of 1,181 received during the examination period that were adjudicated in excess of thirty (30) calendar days.
- One hundred non-electronically received claims from a population of 2,652 claims received during the examination period that were adjudicated in excess of forty-five (45) calendar days.
- One hundred electronically and non-electronically received claims from a population of 483 claims received during the examination period that were adjudicated in excess of ninety (90) calendar days.

Utilization Review

Cigna used International Rehabilitation Associates, Inc., d/b/a Intracorp, to provide the utilization management, case management, demand management, disease management, and care management to support Cigna's healthcare business. Effective December 7, 2010, Intracorp changed its name to CIGNA Health Management, Inc. in its domiciliary state of Delaware, which was also effective subsequently in each state wherein Intracorp was licensed as a foreign corporation as of the date of approval by the respective Secretary of State offices.

The examiners reviewed Cigna's utilization review (UR) management program including policies and procedures. For the period of January 1, 2010 through June 30, 2011, Cigna provided six (6) appeals of adverse determinations that had been received. Four (4) of these were first level appeals and two (2) were second level appeals. The examiners reviewed the files for compliance with statutory requirements.

Using ACL ™ software, the examiners selected the following random samples from the population of 1,472 initial UR decisions made which involved utilization review requests received during 2010.

- One hundred approved initial UR decisions
- One hundred denied initial UR decisions

EXAMINATION REPORT SUMMARY

The examination resulted in a total of nineteen (19) findings in which the Company was not in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: In the area of company operations and management, no issues were identified that exceeded the reporting threshold to be included in this report.

Complaint Handling: In the area of complaint handling, no issues were identified that exceeded the reporting threshold to be included in this report.

Producers: In the area of producers, no issues were identified that exceeded the reporting threshold to be included in this report.

Contract Forms: In the area of contract forms, the examiners identified fourteen (14) issues of concern.

Issue E1: Failure to reflect the required definition of a "significant break in coverage" in the Certificate of Creditable Coverage form used by the Company.

Issue E2: Failure of the Company's forms, in some instances, to reflect correct information concerning conversion coverage.

Issue E3: Failure of the Company's forms, in some instances, to reflect correct or complete coverage to be provided for Home Health Services and Hospice Care.

Issue E4: Failure of the Company's forms, in some instances, to reflect required minimum standards for handling appeals involving utilization review determinations.

Issue E5: Failure to include all required items on the form to be used by enrollees wishing to register written complaints.

Issue E6: Failure of the Company's forms, in some instances, to reflect a complete description of coverage to be provided for hospital stays for newborns and maternity expenses.

Issue E7: Failure of the Company's forms, in some instances, to reflect the correct annual maximum benefit for Early Intervention Services from January 1, 2010 until September 23, 2010.

Issue E8: Failure of the Company's forms, in some instances, to allow prescription drug benefits due to a covered person's addiction to or dependency on tobacco.

Issue E9: Failure of the Company's forms, in some instances, to reflect the complete coverage required for hearing aids for children.

Issue E10: Failure of the Company's forms, in some instances, to correctly reflect the required coverage for inherited enzymatic disorders.

Issue E11: Failure of the Company's forms, in some instances, to provide accurate information regarding the responsibility to track member copayments and copayment maximums.

(The examiners identified this as a repeat of prior issue E1 in the findings of the 2005 final examination report.)

Issue E12: Failure of the Company's forms, in some instances, to reflect correct information regarding the subscribers' option to continue coverage.

Issue E13: Failure of the Company's forms, in some instances, to reflect the required disclosure regarding specific counties with no participating providers.

Issue E14: Failure of the Company's forms, in some instances, to reflect a correct definition of a disabled dependent. *(This was part of prior issue E2 in the findings of the 2005 final examination report.)*

Rates: In the area of rates, the examiners identified one (1) issue of concern in their review.

Issue F1: Providing a premium discount to some groups at renewal that was not included in any rate filing or group contract.

New Business Applications: In the area of new business applications, no issues were identified that exceeded the reporting threshold to be included in this report.

Cancellations, Declinations and Rescissions: In the area of cancellations, declinations and rescissions, no issues were identified that exceeded the reporting threshold to be included in this report.

Claims Handling: In the area of claims handling, the examiners identified two (2) issues of concern in their review.

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay late payment penalties due on claims.

Utilization Review: In the area of utilization review, the examiners identified two (2) issues of concern in their review.

Issue K1: Failure, in some instances, to have initial denial of benefit letters or first level review adverse determinations signed by a licensed physician.

Issue K2: Issue removed.

Issue K3: Failure, in some instances, to provide covered persons the twenty (20) day advance notice required for voluntary second level reviews. *(The examiners identified this as a repeat of prior issue K7 in the findings of the 2005 final examination report.)*

CIGNA HEALTHCARE OF COLORADO, INC.

FACTUAL FINDINGS

CONTRACT FORMS

Issue E1: Failure to reflect the required definition of a "significant break in coverage" in the Certificate of Creditable Coverage form used by the Company.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

. . .

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety days* prior to the effective date of the new coverage. . . . [Emphasis added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority of §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days.* For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

2. *Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.*

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, *if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.*

. . .

4. Certifying creditable coverage

   Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. *However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphases added.]

The certificate of creditable coverage form used by Cigna was not in compliance with Colorado insurance law in that the form did not reflect the definition of "significant break in coverage" as required by Colorado insurance law. Colorado law prevails over the federal regulations and indicates creditable coverage may be credited and certified if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Since the covered individual may be subject to a different time period for a significant break in coverage, the certificate of creditable coverage must include the definition contained in Colorado Insurance Regulation 4-2-18.

The "Certificate of Individual Health Insurance Coverage" form in use by the Company reflected:

Statement of HIPAA Portability Rights

Preexisting condition exclusions.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for *63 days* or more without coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a *63-day* break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to individual health coverage.

- You have had coverage for at least 18 months without a break in coverage of *63 days* or more;

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

> Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a *63-day break*. [Emphases added.]

Form Name	Form Number
Certificate of Individual Health Insurance Coverage	None

Recommendation No. 1:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its certificate of creditable coverage form to include the definition of a "significant break in coverage" as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with a specimen copy of the revised form that contains a compliant definition of a "significant break in coverage" and provide the proposed date the revised form will be put in use.

Issue E2: Failure of the Company's forms, in some instances, to reflect correct information concerning conversion coverage.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

> . . .
>
> (2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.
>
> (a) *Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by* a nonprofit hospital, medical-surgical, and health service corporation or *a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).*
>
> (b)(I) An employee *shall be eligible* to make the election for such employee and the employee's dependents provided for in paragraph (a) of this subsection (2) if:
>
> (A) The employee's eligibility to receive insurance coverage has ended for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class;
>
> (B) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and
>
> (C) The employee has been continuously covered under the group contract, or under any group contract providing similar benefits which it replaces, for at least six months immediately prior to termination.
>
> . . .
>
> (III) The employer shall not be required to offer continuation of coverage of any person *if such person is covered by medicare, Title XVIII of the federal "Social Security Act", or medicaid, Title XIX of the federal "Social Security Act".* [Emphases added.]

Cigna was not in compliance with Colorado insurance law in that the evidence of coverage forms for its Basic and Standard conversion plans reflected that members (subscriber or dependent) did not have the right to conversion coverage if they were eligible for Medicare.

Colorado insurance law states that an offer of continuation/conversion coverage need not be extended if Medicare already *covers* the member when they become eligible for conversion coverage. An applicant for conversion coverage may not be refused solely because of their *eligibility* for Medicare.

Page 11 of the Company's evidence of coverage for the "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" reflected:

SECTION VI: Eligibility

SUBSCRIBER

To be eligible to enroll as a SUBSCRIBER, an individual must:

. . .

2. not be ineligible by reason of any of the provisions of the "Specific Causes for Ineligibility" Section.

Dependent

To be eligible to enroll as a Dependent, an individual who is not ineligible by reason of any of the "Specific Causes for Ineligibility" of this Section must be at the time of enrollment:

SPOUSE The SUBSCRIBER'S legal spouse who resides in the Service Area.

If the spouse is eligible for Medicare benefits, then the spouse is not eligible as a Dependent under the terms of the Agreement.

CHILDREN A natural child, adopted child, step-child, a child supported by the SUBSCRIBER pursuant to a valid court order or a child for whom the SUBSCRIBER, is the legal guardian, if the child:

. . .

4. is not eligible for Medicare Part A (Hospital) and Part B (Medical).

Specific Causes for Ineligibility

An individual shall not be entitled to enroll as a SUBSCRIBER or Dependent if:

. . .

3. the individual is eligible for Medicare; or

Form Name	Form Number
Colorado Basic HMO Conversion Plan without Specified Mandates	CO.ICA-BASIC-2008
Colorado Standard HMO Conversion Plan	CO.ICA-STANDARD-2008

Recommendation No. 2:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-108, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect correct eligibility requirements for conversion with regard to eligibility for, versus being covered by, Medicare, as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms containing compliant language concerning eligibility requirements for conversion and provide the proposed date the revised forms will be put in use.

Issue E3: Failure of the Company's forms, in some instances, to reflect correct or complete coverage to be provided for Home Health Services and Hospice Care.

Colorado Insurance Regulation 4-2-8 (amended February 1, 2001), Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S., states in part:

. . .

Section 4. Requirements for Home Health Services

A. Definitions.

. . .

(3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to 4 hours by a home health aide shall be considered as one visit.

(4) "*Medical social services*" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition. [Emphases added.]

. . .

C. Benefits for Home Health Care Services.

. . .

(3) The policy offered shall include benefits for the following services:

. . .

(e) Speech therapy and *audiology*;

Section 5. Requirements for Hospice Care

A. Definitions.

(1) A "hospice" is a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. Hospice services shall be

provided *in the home,* a licensed hospice, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

(2) "Hospice care" is an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. *Supportive services are offered to the family before and after the death of the patient*. Hospice care is not limited to medical intervention, but addresses physical, social, psychological, and spiritual needs of the patient. Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

. . .

(4) *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties*.

. . .

(12) "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

. . .

(15) "Hospice levels of care:"

. . .

(c) *"Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less*.

(16) *"Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period*.

. . .

(18) *A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.*

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

(20) *An "unrelated illness" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness*.

B. General Provisions Pertaining to Hospice Care.

. . .

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, *except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care*.

. . .

(5) *The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.*

C. Benefits for Hospice Care Services.

. . .

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

(a) *Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.*

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer,

provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian. [Emphases added.]

Colorado Insurance Regulation 4-2-8 (amended March 2, 2011), Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S., states in part:

. . .

Section 4 Requirements for Home Health Services

A. Definitions.

. . .

2.(d) Social Work Practice services, as defined in § 12-43-403, C.R.S., by a licensed social worker. "Licensed Social Worker" shall have the same meaning as provided in § 12-43-201(5.5).

. . .

C. Benefits for Home Health Care Services.

. . .

3. The policy offered shall include benefits for the following services:

. . .

(e) Speech and language therapy;

(f) *Respiratory* and inhalation therapy;

(g) *Nutrition counseling by a nutritionist or dietitian*;

(h) *Social work practice services;*

(i) Medical supplies;

(j) Prosthesis and *orthopedic appliances*;

(k) Rental or purchase of durable medical equipment; and

(l) Drugs, medicines, or insulin.

4. *The services identified in C3(i) through C3(l) of this section may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.*

Section 5 Requirements for Hospice Care

A. Definitions.

1. A "hospice" is a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychosocial, spiritual, and bereavement care for terminally ill individuals and their families to be available 24 hours, 7 days a week. Hospice services shall be provided *in the home*, a hospice facility, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

2. "Hospice care" is an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. *Supportive services are offered to the family before and after the death of the patient.* Hospice care is not limited to medical intervention, but addresses physical, psychosocial, and spiritual needs of the patient. Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers.

. . .

4. *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the*

primary or designated care giver and individuals with significant personal ties.

. . .

10. "Home care services" are hospice services, *which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*.

. . .

12. "Hospice levels of care:"

. . .

(c) *"Inpatient hospice respite care." The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.*

13. *"Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.*

. . .

15. *A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.*

16. A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

17. *An "unrelated illness" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness*.

. . .

C. Benefits for Hospice Care Services.

. . .

3. The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above.

a. Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1,400. [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS
FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2010

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

Benefit Grid

JANUARY 1, 2010 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

and

JULY 1, 2010 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

and

NOVEMBER 1, 2010 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

and

FEBRUARY 1, 2011 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO AND HMO

PART A: TYPE OF COVERAGE

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	

PART B: SUMMARY OF BENEFITS

25. HOME HEALTH CARE [18a]	$20 copay per visit Limited to 60 visits per year
26. HOSPICE CARE [18a, 18b]	$50 inpatient per diem copay $20 outpatient per diem copay

[18a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[18b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

Benefit Grid

JANUARY 1, 2010 COLORADO STANDARD HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

and

JULY 1, 2010 COLORADO STANDARD HEALTH BENEFIT PLANS:
INDEMNITY, PPO AND HMO

and

NOVEMBER 1, 2010 COLORADO STANDARD HEALTH BENEFIT PLANS:
INDEMNITY, PPO AND HMO

and

FEBRUARY 1, 2011 COLORADO STANDARD HEALTH BENEFIT PLANS:
INDEMNITY, PPO AND HMO

PART A: TYPE OF COVERAGE

STANDARD HMO PLAN	

PART B: SUMMARY OF BENEFITS

25. HOME HEALTH CARE [22a]	No Copay (100% covered)
26. HOSPICE CARE [22a, 22b]	No Copay (100% covered)

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[22b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

Cigna was not in compliance with Colorado insurance law with regard to Home Health Services and Hospice Care that were required to be provided in its offered Basic and Standard conversion plans in that:

Lack of benefits reflected in plans

Page 27 of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" forms reflected:

> "Hospice Care Services" do not include the following:
>
> - bereavement counseling;
>
> . . .
>
> - nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

During the period under examination, bereavement support services for the family of the deceased person during the twelve month period following death were to be provided.

Medical supplies were one of the benefits to have been included and were subject to the policy's deductible, coinsurance and stoploss provisions, which were exclusive of and shall not have been included in, the dollar limitation for home care hospice benefits.

Incomplete information reflected in plans

Page 7 of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" forms reflected:

> SECTION V: Definitions
>
> Hospice Care Services means any services provided by:
> (a) a Participating Hospital, (b) a participating skilled nursing facility or a similar institution, (c) a participating home health care agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program, and is a Medicare approved Hospice Care Program.
>
> Hospice Facility means a participating institution or part of it which primarily provides care for Terminally Ill patients; is a Medicare approved hospice care

> facility; meets standards established by HEALTHPLAN; and fulfills all licensing requirements of the state or locality in which it operates.

Page 8 of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" forms reflected:

> Other Participating Health Care Facility means any facility other than a Participating Hospital or Hospice Facility which is operated by or has an agreement with HEALTHPLAN to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities and rehabilitation hospitals.

Page 21 of the company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" forms reflected:

SECTION XI: Services and Benefits

Home Health Services

> Home health services are provided for a Member who requires skilled care, is unable to receive medical care on an ambulatory outpatient basis, and does not require confinement in a Hospital or Other Participating Health Care Facility. Home health services shall be provided by an accredited home health agency which is a Participating Provider. Home Health Services include visits by professional nurses and Other Participating Health Professionals (including home health aids [sic]), consumable medical supplies and durable medical equipment administered or used by such persons in the course of services rendered during such visits, medical social services for the terminally ill, and drugs and medications prescribed by a Participating Physician. Physical, occupational and speech therapy provided in the home are subject to the benefit imitations described under "Physical, Occupational and Speech Therapy" in this Section.

Hospice home care services are required to be provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. The plans do not reflect this.

It is to be clearly indicated in the plans that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries. There is no indication of this in the plans.

The plans do not indicate that "audiology" and "respiratory" therapies are home health services for which benefits are to be provided.

There is no indication that services up to four (4) hours by a home health aide shall be considered as one (1) visit.

Non-compliant exclusions reflected in plans

Page 30 of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" forms reflected:

SECTION XII: Exclusions and Limitations

. . .

24. Artificial aids including, but not limited to, *crutches; splints; braces; corrective orthopedic shoes; arch supports*; elastic stockings; garter belts; corsets; hearing aids; eyeglass lenses and frames; contact lenses (except for the treatment of keratoconus or post-cataract surgery); dentures and wigs.

25. External and internal *prosthetic medical appliances, including, but not limited to, artificial arms; legs;* and terminal devices such as a hand or hook, penile prosthetic appliances; biomechanical devices and experimental or investigational devices. [Emphasis added.]

During the period under examination, rental or purchase of durable equipment was to be a covered hospice care benefit to be supplied, subject to the policy's deductible, coinsurance and stoploss provisions, and should not have been included in, the dollar limitation for home care hospice benefits. Crutches, splints, and braces fell under the definition of durable medical equipment.

Orthopedic appliances were a hospice care benefit to have been supplied, subject to the policy's deductible, coinsurance and stoploss provisions, which were exclusive of and shall not be included in, the dollar limitation for home care hospice benefits. Corrective orthopedic shoes and arch supports fell under the definition of orthopedic appliances.

Prosthetics were a hospice care benefit to have been supplied, subject to the policy's deductible, coinsurance and stoploss provisions, which were exclusive of, and shall not be included in, the dollar limitation for home care hospice benefits. Prosthetic medical appliances, including artificial arms and legs fall under the definition of prosthesis.

Page 34 of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" forms reflected the following exclusion:

SECTION XII: Exclusions and Limitations

. . .

47. Immunization agents, biological products for allergy immunization, *biological sera, blood, blood plasma and other blood products or fractions.* [Emphasis added.]

Drugs and biologicals were a hospice care benefit to have been supplied, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in, the dollar limitation for home care hospice benefits. Biological sera, blood, blood plasma and other blood products or fractions fell under the definition of biologicals.

Form Name	Form Number
Colorado Basic HMO Conversion Plan without Specified Mandates	CO.ICA-BASIC-2008
Colorado Standard HMO Conversion Plan	CO.ICA-STANDARD-2008

Recommendation No. 3:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulations 4-2-8 and 4-6-5. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable certificates and any other policy forms to reflect correct and complete coverage to be provided for Home Health Services and Hospice Care as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms containing complete and correct Home Health Services and Hospice Care benefits, and provide the proposed date the forms will be put in use.

Issue E4: Failure of the Company's forms, in some instances, to reflect required minimum standards for handling appeals involving utilization review determinations.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

. . .

Section 2	Background and Purpose	(eff. 02/01/06)
Section 2	Scope and Purpose	(eff. 11/01/10)

. . .

This regulation is designed to provide minimum standards for handling appeals and grievances involving utilization review determinations and certain denials of benefits for treatments excluded by health coverage plans. [Emphasis added.]

. . .

Section 10. First Level Review

A. A health carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request. The procedures shall specify whether a first level review request must be in writing or may be submitted orally. The procedures shall also allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision.

. . .

E. Conduct of first level reviews.

1. First level reviews *shall be evaluated by a physician* who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions. [Emphasis added.]

Section 11. Voluntary Second Level Review

A. A carrier shall establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, selected by the carrier. The procedures *shall allow the covered person to identify providers to whom the health carrier shall send a copy of the second level review decision.* The purpose of the voluntary review process is to give the covered person the opportunity to explain their

grievance and to provide any relevant evidence in support of their claim for benefits. [Emphasis added.]

. . .

F. Procedures. [Effective 11/01/10]

. . .

2. The reviewer or review panel, shall meet the following criteria:

a. Were not previously involved in the appeal, and

b. Who do not have a direct financial interest in the appeal or outcome of the review. [Emphasis added.]

The Complaints and Grievance procedures reflected in the Company's Basic and Standard conversion plans and Cigna's HealthCare Handbook and Group Service Agreement, used as the evidence of coverage for its four (4) stand-alone plans, were not in compliance with Colorado insurance law in the following ways:

First Level Review

- The plans indicated that first level reviews and decisions would be made by "*someone"* not involved in the initial decision. Colorado insurance law requires first level reviews to be evaluated by a *physician* not involved with the initial denial.

Page 37a of the Company's "Basic HMO Conversion Plan without Specified Mandates, the "Standard HMO Conversion Plan"; and Page 30 of the "Cigna HealthCare Handbook and Group Service Agreement" reflect:

SECTION XIII: Complaints and Grievance Procedure

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision.

Voluntary Second Level Review

- There is no mention of the provision that allows the covered person to identify providers to whom the health carrier shall send a copy of the review decision.

- The plans were not in compliance with Colorado insurance law from November 1, 2010 through June 30, 2011, as the plans did not include the amended regulation language which stipulates that the reviewer or the review panel must not have a direct financial interest in the appeal or outcome of the review.

Page 37a of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan"; and Page 31 of the "Cigna HealthCare Handbook and Group Service Agreement" form reflected:

> Level Two Appeal
>
> If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Form Name	Form Number
Colorado Basic HMO Conversion Plan without Specified Mandates	CO.ICA-BASIC-2008
Colorado Standard HMO Conversion Plan	CO.ICA-STANDARD-2008
Cigna HealthCare Handbook and Group Service Agreement	GSA

Stand-Alone Plans

HMO1-HMO
HMO4-HMO
CHA1-POS
CHA4-POS Open Access

Recommendation No. 4:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable forms to reflect the required minimum standards for utilization review, as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all applicable forms containing appeal and grievance procedures and provide the proposed date that the forms will be put in use.

Issue E5: Failure to include all required items on the form to be used by enrollees wishing to register written complaints.

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated under the authority of § 10-16-109, C.R.S., states in part:

> . . .
>
> Section 8 Other Requirements
>
> . . .
>
> D. Complaint System
>
> . . .
>
> 2. An HMO shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include the address and telephone number to which complaints must be directed *and shall specify any required time limits imposed by the HMO.* [Emphasis added.]

Cigna's form for members who wish to submit a written appeal of an adverse decision is not in compliance with Colorado insurance law in that it does not include the following required item:

- Any required time limits imposed by the Health Maintenance Organization

Form Name	Form Number
Request For Member Appeal	None

Recommendation No. 5:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-7-2. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable policy forms to reflect all information related to submission of a complaint, as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all applicable forms reflecting the required items for members wishing to submit a written appeal of an adverse decision and provide the proposed date that the forms will be put in use.

Issue E6: Failure of the Company's forms, in some instances, to reflect a complete description of coverage to be provided for hospital stays for newborns and maternity expenses.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn Children.

. . .

(b)(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.*

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8:00 p.m., coverage shall continue until 8 a.m. the following morning*. [Emphases added.]

. . .

(3) Maternity coverage.

. . .

(a)(II) Coverage for a hospital stay following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning*.

(III) Coverage for a hospital stay following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.* [Emphases added.]

Cigna was not in compliance with Colorado insurance law in that the forms identified below reflected an incomplete description of the mandated minimum hours of coverage to be allowed for in-patient maternity and newborn services by failing to reflect that if the forty-eight (48) or ninety-six (96) hour minimum coverage falls after 8:00 p.m., the in-patient benefits will be covered until 8:00 a.m. the following morning.

Page 22 of the Company's "Colorado Basic HMO Conversion Plan without Specified Mandates" and the "Colorado Standard HMO Conversion Plan" reflected:

Maternity Care Services

. . .

> Coverage for a mother and her newly born child shall be provided for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section.

Page 55 of the Company's "Cigna Healthcare Handbook and Group Service Agreement", the evidence of coverage form used for the four (4) stand-alone plans reflected:

> Maternity Care Services
>
> . . .
>
> Coverage for a mother and her newly born child shall be provided for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

Form Name	Form Number
Colorado Basic HMO Conversion Plan without Specified Mandates	CO.ICA-BASIC-2008
Colorado Standard HMO Conversion Plan	CO.ICA-STANDARD-2008

Stand-Alone Plans

HMO1-HMO
HMO4-HMO
CHA1-POS
CHA4-POS Open Access

Recommendation No. 6:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable forms to reflect a complete description of the coverage to be provided for hospital stays for newborns and maternity expenses as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms containing a complete description of the coverage to be provided for hospital stays for newborns and maternity expenses and provide the proposed date that the forms will be put in use.

Issue E7: Failure of the Company's forms, in some instances, to reflect the correct annual maximum benefit for Early Intervention Services from January 1, 2010 until September 23, 2010.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1.3) Early intervention services.

. . .

(b)(II) The coverage required by this subsection (1.3) shall be available annually to an eligible child from birth up to the child's third birthday and shall be limited to five thousand seven hundred twenty-five dollars, including case management costs, for early intervention services for each dependent child per calendar or policy year. For policies or contracts issued or renewed on or after January 1, 2009, and *on or after each January 1 thereafter, the limit shall be adjusted by the division based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year, or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase.* [Emphasis added.]

Colorado Regulation 4-2-28, Concerning the Payment of Early Intervention Services for Children Eligible for Benefits Under Part C of the Federal "Individuals With Disabilities Education Act", promulgated under the authority of §§10-1-109 and 27-10.5-704(2), C.R.S., states in part:

. . .

Section 5 Rules

. . .

D. Carrier payment guidelines.

. . .

3. As of January 1, 2009, the maximum annual benefit payable for all eligible early intervention and case management services is $5,935.00. Thereafter, on January 1 of each year, the maximum annual benefit payable shall be adjusted based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year or by such additional amount to be equal to the increase by the General Assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the

> consumer price index increase. *The new maximum annual benefit amount will be published in a bulletin by the Colorado Division of Insurance.* [Emphasis added.]

Bulletin No. B-4.31, Concerning the Annual Maximum Benefit for Early Intervention Services, states in part:

> I. Background and Purpose
>
> The purpose of this bulletin is to provide carriers with the annual maximum benefit amount for early intervention services effective January 1, 2010.
>
> Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.
>
> II. Applicability and Scope
>
> This bulletin is intended for all group and individual sickness an accident insurance policies and all service or indemnity contracts issued by licensed carriers, including health maintenance organizations, in the state of Colorado.
>
> III. Division Position
>
> Section 10-16-104(1.3)(b)(II), C.R.S., specifies that the annual maximum benefit amount will be adjusted by the Colorado Division for Developmental Disabilities for policies issued or renewed on or after each January 1 based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area. *The annual maximum benefit amount effective January 1, 2010 is $6,036.* [Emphasis added.]

Cigna's "Schedule of Copayments" used with its four (4) stand-alone plans, reflected an incorrect annual maximum benefit amount for Early Intervention Services from January 1, 2010 to September 23, 2010. The new annual maximum benefit amount is adjusted on January 1 of each year and this benefit amount is published in a bulletin by the Colorado Division of Insurance. Cigna provided documentation to the examiners that it removed the cap for this benefit in order to comply with federal Healthcare Reform on September 23, 2010.

Page 5 of the Company's "Schedule of Copayments" document reflected:

> Child Early Intervention Services
>
> Coverage from birth until the child's 3rd birthday. *$5,935*
> Maximum per child per calendar year. (not subject to deductibles or copayments, not applied to any maximum lifetime or annual benefit limits otherwise specified in the plan) [Emphasis added.]

Form Name	Form Number
Schedule of Copayments	GSA-SOC CO-L
Stand-Alone Plans	
HMO1-HMO	
HMO4-HMO Open Access	
CHA1-POS	
CHA4-POS Open Access	

Recommendation No. 7:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-28.

The Division's records indicate that prior to the issuance of this MCE Report, Cigna provided documentation to the Division of corrective actions, which if fully implemented, would bring Cigna into compliance with the requirement to reflect the correct annual maximum benefit for Early Intervention Services in its contract forms.

Issue E8: Failure of the Company's forms, in some instances, to allow prescription drug benefits due to a covered person's addiction to or dependency on tobacco.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (18) Preventive health care services.
>
> (a)(I) Except as specified in subparagraph (II) of this paragraph (a), the following policies and contracts that are delivered, issued, renewed, or reinstated on or after January 1, 2010, *shall provide coverage for the total cost of the preventive health care services specified in paragraph (b) of this subsection (18)*:
>
> . . .
>
> (B) All individual and group health care service or indemnity contracts issued by an entity subject to part 3 or 4 of this article;
>
> (b) The coverage required by this subsection (18) *shall include preventive health care services for the following, in accordance with the A or B recommendations of the task force for the particular preventive health care service:* [Emphases added.]
>
> . . .
>
> (IX) Tobacco use screening of adults and tobacco cessation interventions by primary care providers.

Cigna was not in compliance with Colorado insurance law in that it excluded coverage for prescription smoking cessation products, which are included in the recommendations of the U.S. Preventive Services Task Force.

The examiners reviewed the "Supplemental Rider Prescription Drugs" that is used with the four (4) Cigna stand-alone products in use or available for use in Colorado during the examination period. This rider incorrectly excluded coverage for prescription smoking cessation products. The recommended treatment by the U.S. Preventive Services Task Force included in a tobacco cessation intervention by a primary care provider, includes FDA-approved "pharmacotherapy", including nicotine replacement therapy, sustained-release bupropion, and varenicline.

Page 6 of the Supplemental Rider for Prescription Drugs reflected:

> V. Exclusions
> Version 2 (new exclusion)
>
> 12. Prescription smoking cessation products.

Form Name	Form Number
Supplemental Rider Prescription Drugs	RX-MG-CO-F

Recommendation No. 8:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable forms to remove the exclusion for prescription smoking cessation products as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms reflecting removal of the exclusions for prescription smoking cessation products and provide the proposed date that the forms will be put in use.

Issue E9: Failure of the Company's forms, in some instances, to reflect the complete coverage required for hearing aids for children.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(19) Hearing aids for children – legislative declaration.

. . .

(b) Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, shall provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 36 of title 12, C.R.S., and by an audiologist licensed pursuant to section 12-5.5-102, C.R.S. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. *Coverage shall include the purchase of the following*:

. . .

(II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; [Emphases added.]

Colorado Insurance Regulation 4-2-30, Concerning the Rules for Complying with Mandated Coverage of Hearing Aids and Prosthetics, promulgated under the authority of §10-1-109, C.R.S., states in part:

. . .

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed on or after January 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

. . .

C. "Hearing aid" shall have the same meaning as set forth in §10-16-102(24.7), C.R.S.

Section 5 Rules

A. Hearing aids.

1. For the purposes of §10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, *any*

> *benefits paid for a minor child's hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual or lifetime durable medical equipment maximum, if any.*
>
> . . .
>
> 3. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years*; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids.* [Emphases added.]

Cigna was not in compliance with Colorado insurance law in that the plans identified below included a description of the coverage to be provided for hearing aids for children that was incomplete in the following ways:

- The plans did not reflect the provision that a new hearing aid is to be covered when alterations to the existing hearing aid(s) cannot adequately meet the needs of the child.

- Nothing was reflected to indicate that any benefits paid for a child's hearing aid(s) cannot be used to exhaust the plan's annual or lifetime durable medical equipment maximum, if any.

Page 51 of the Company's "Cigna HealthCare Handbook and Group Service Agreement", used as the evidence of coverage for its four (4) stand-alone plans, reflected:

> Hearing Aids for Children
>
> Coverage will be provided for hearing aids and audiological services for children up to eighteen (18) years of age. *Benefits will be paid the same as any other covered benefit including the same annual deductible or copayment.* Benefits are subject to utilization review and are covered benefits only if deemed medically necessary. [Emphasis added.]

Page 5 of the Company's "Schedule of Copayments" document reflected:

Durable Medical Equipment	
[$100-$500 deductible per member per contract year]	[No charge: $0-50; and/or 0-50% Copayment per item] [after the deductible.]
[$500-5,000 maximum per member per contract year]	

Form Name	Form Number
Schedule of Copayments	GSA-SOC CO-L

Stand-Alone Plans

HMO1-HMO
HMO4-HMO
CHA1-POS
CHA4-POS Open Access

Recommendation No. 9:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-30. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect complete coverage to be provided for hearing aids for children as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms reflecting complete coverage to be provided for hearing aids for children and provide the proposed date the forms will be put in use.

Issue E10: Failure of the Company's forms, in some instances, to correctly reflect the required coverage for inherited enzymatic disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> (1) Newborn children.
>
> (a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.
>
> . . .
>
> (c)(I) Except as provided for cleft lip and cleft palate coverage in sub-subparagraph (A) of subparagraph (II) of this paragraph (c) and for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist pursuant to sub-subparagraph (A) of subparagraph (III) of this paragraph (c), the benefits available to newborn children shall consist of . . .
>
> . . .
>
> (III)(B) *There is no age limit on benefits for inherited enzymatic disorders specified in sub-paragraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age*.
>
> (C) As used in this subparagraph (III), *"medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids* and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients. [Emphases added.]

Cigna's evidence of coverage for its four (4) stand-alone plans was not in compliance with Colorado insurance law in what is reflected as an exclusion for nutritional supplements and formulae for the treatment of inherited enzymatic disorders. Coverage for these nutritional supplements and formulae are not limited to infants, and have no age limit applied except for phenylketonuria.

Page 87 of the Cigna HealthCare Handbook and Group Service Agreement reflected:

SECTION V. EXCLUSIONS AND LIMITATIONS

Exclusions

. . .

40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.

Form Name	Form Number
Cigna HealthCare Handbook and Group Service Agreement	GSA

Stand-Alone Plans

HMO1-HMO
HMO4-HMO Open Access
CHA1-POS
CHA4-POS Open Access

Recommendation No. 10:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect the required coverage for inherited enzymatic disorders as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms containing compliant coverage for inherited enzymatic disorders and provide the proposed date the forms will be put in use.

Issue E11: Failure of the Company's forms, in some instances, to provide accurate information regarding the responsibility to track member copayments and copayment maximums. (*The examiners identified this as a repeat of prior issue E1 in the findings of the 2005 final examination report.)*

Section 10-16-107, C.R.S., Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain, reflects in part:

. . .

(3)(b) An evidence of coverage shall contain:

(I) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in section 10-16-413(1);

Section 10-16-413, C.R.S., Prohibited practices, states in part:

(1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of part 1 of this article and this part 4:

(a) A statement or item of information is deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan. [Emphasis added.]

(b) A statement or item of information is deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

(c) An evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

Cigna HealthCare's Handbook and Group Service Agreement, used as the evidence of coverage for its four (4) stand-alone plans, is not in compliance with Colorado insurance law in that its forms reflect that

covered members are responsible for keeping track of payment of their copayments and notifying the Company when they have reached the copayment maximum set forth in their contract.

This requirement forces members to provide information that the Company should already be maintaining or aware of. It is the Company's responsibility to maintain records relating to copayments paid by members, and when the maximums have been reached in order to properly adjudicate claims. This requirement potentially places members in an adversarial position that could lead to delays and/or improper payment in the settlement of claims, or termination of coverage for cause in the case of unpaid copayments.

The Division recognizes that it is in the members' best interest to keep a record of their out-of-pocket expenses in order to ensure that they are receiving correct benefit payment; however, as the maximum out-of-pocket expenditure is a contractual provision, it is the Company's responsibility to administer it accurately.

Page 16 of the Company's "Cigna HealthCare Handbook and Group Service Agreement", used as the evidence of coverage for its four (4) stand-alone plans, reflected:

> [Total Copayment Maximums]
>
> . . . It is the Subscriber's responsibility to maintain a record of Copayments which have been paid and to inform the Healthplan when the amount reaches the Total Copayment Maximums. The Total Copayment Maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

Form Name	Form Number
Cigna HealthCare Handbook and Group Service Agreement	GSA

Stand-Alone Plans

HMO1-HMO
HMO4-HMO Open Access
CHA1-POS
CHA4-POS Open Access

Recommendation No. 11:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-16-107, and 10-16-413, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect that members do not carry the primary responsibility of maintaining records relating to copayments and copayment maximums as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the

Division with specimen copies of revised policy forms containing compliant language concerning the responsibility of maintaining records relating to copayments and copayment maximums and provide the proposed date the forms will be put in use.

In the market conduct examination for the period January 1, 2005 through December 31, 2005, Cigna was cited for failure to properly track member copayments and copayment maximums. The violation resulted in Item # 10 of Final Agency Order O-08-011 that indicated the Company was required to revise all applicable forms to indicate that members do not carry the primary responsibility of maintaining records relating to copayments and copayment maximums to ensure compliance with Colorado insurance law. Having been previously ordered to revise its forms in this manner, the Company knew or should have reasonably known that its continued use of such forms during the current examination period constituted a repeat violation of §10-16-104, C.R.S., providing grounds for an increased penalty pursuant to § 10-1-205(3)(d), C.R.S.

Issue E12: Failure of the Company's forms, in some instances, to reflect correct information regarding the subscribers' option to continue coverage.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

. . .

(2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

(a) Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a nonprofit hospital, medical-surgical, and health service corporation *or a health maintenance organization* operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. *Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).*

. . .

(c)(III) The employee shall notify the employer in writing of the employee's election to continue coverage, and shall make proper payment to the employer as soon as possible upon notification by the employer of termination; however, *in no case shall such notification occur or such payment be made more than thirty days after the date of termination of employment* unless the employer has failed to give timely notice in accordance with subparagraph (II) of this paragraph (c). Timely submission of payment and notice by the employee shall result in the continuation of such employee's health care coverage as if there had been no interruption of coverage. Failure to timely submit proper payment and notice by the employee shall relieve the employer of any responsibility to the employee for the continuation of health care coverage.

(IV) If the employer fails to notify an eligible employee of the right to elect to continue the coverage, *the employee shall have the option to retain coverage if, within sixty days of the date such employment is terminated,* such employee makes the proper payment to the employer to provide continuous coverage. [Emphases added.]

Cigna's evidence of coverage for its four (4) stand-alone plans was not in compliance with Colorado insurance law in the time frames reflected for a subscriber to:

(1) Make proper payment to the employer to provide continuous coverage if the employer fails to notify the subscriber of the right to elect to continue the coverage.

- Sixty (60) days is allowed; however, thirty (30) days is reflected.

(2) Provide written notification to the employer of the subscriber's election to continue coverage and make proper payment as soon as possible upon notification by the employer of termination.

- Thirty (30) days is allowed; however, twenty (20) days is reflected.

Pages 100 and 101 of the Company's "Cigna HealthCare Handbook and Group Service Agreement" reflect:

Continuation of Coverage Under Colorado Law

4. . . . If the Group fails to notify an eligible Subscriber of his right to elect Continuation of Coverage, the Subscriber shall have the option to retain coverage if, within *thirty (30) days* of the date his employment is terminated, he makes the proper payment to the Group to provide continuous coverage.

5. Notice by Subscriber. The Subscriber shall notify the Group in writing of his election of Continuation of Coverage for himself and his Dependents, if any, and shall make proper payment to the Group as soon as possible upon notification by the Group of termination; however; in no case shall such notification occur or such payment be made *more than twenty (20) days* from the date of termination of employment. . . . [Emphases added.]

Form Name	Form Number
Cigna HealthCare Handbook and Group Service Agreement	GSA

Stand-Alone Plans

HMO1-HMO
HMO4-HMO Open Access
CHA1-POS
CHA4-POS Open Access

Recommendation No. 12:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-108, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect correct information to allow subscribers to continue coverage as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms reflecting correct information to allow subscribers to continue coverage and provide the proposed date the forms will be put in use.

Issue E13: Failure of the Company's forms, in some instances, to reflect the required disclosure regarding specific counties with no participating providers.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration, states in part:

. . .

(2)(d) The carrier shall provide, *in conspicuous, bold-faced type,* an understandable disclosure in *policy contract materials, certificates of coverage* for a policyholder, and marketing materials about the following:

(I) *Specific counties of the state where there are no participating providers*;

Cigna's evidence of coverage and Schedule of Copayments, (which is a supplement to the evidence of coverage), used with the four (4) stand-alone plans, were not in compliance with Colorado insurance law in that the required disclosure regarding specific counties of the state where there were no participating providers was not displayed in either form.

Form Name	Form Number
Cigna HealthCare Handbook and Group Service Agreement	GSA
Schedule of Copayments	GSA-SOC CO-L 11/09

Stand-Alone Plans

HMO1-HMO
HMO4-HMO Open Access
CHA1-POS
CHA4-POS Open Access

Recommendation No. 13:

Cigna shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-704, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date that this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect specific counties of the state where there are no participating providers as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms that reflect specific counties of the state where there are no participating providers and the date the forms will be put in use.

Issue E14: Failure of the Company's forms, in some instances, to reflect a correct definition of a disabled dependent. *(This was part of prior issue E2 in the findings of the 2005 final examination report.)*

Section 10-16-102, C.R.S., Definitions, states in part:

> . . .
>
> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as *disabled* and *dependent* upon the parent. [Emphasis added.]

Cigna's evidence of coverage for its four (4) stand-alone plans was not in compliance with Colorado insurance law in that the form reflected an overly restrictive and misleading definition of a disabled dependent. The Company's definition of a disabled dependent specified that the child be:

- "permanently and continuously" disabled; and
- that the disability be the result of "mental retardation or physical handicap".

Colorado insurance law does not allow such qualifying restrictions to be placed on the definition of a disabled dependent. Disability can be caused by factors other than mental retardation or physical handicap and in some cases, can be temporary in nature. The restrictions placed on the definition (and presumably eligibility) of disabled dependents by the Company could result in the denial of coverage to individuals who would otherwise be entitled to such coverage under Colorado insurance law.

Page 18 of the Cigna HealthCare Handbook and Group Service Agreement reflected:

> SECTION 11. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE
>
> Who can enroll as a Member
>
> . . .
>
> B. To be eligible to enroll as a Dependent, you must:
>
> . . .
>
> 2. be the unmarried natural child, step-child, or adopted child of the Subscriber, or the child for whom the Subscriber is the legal guardian, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:
>
> . . .

c. the child is *permanently and continuously incapable* of self-sustaining support by reason of *mental retardation or physical handicap,* as certified by a physician. … [Emphasis added.]

Form Name	Form Number
Cigna HealthCare Handbook and Group Service Agreement	GSA

Stand-Alone Plans

HMO1-HMO
HMO4-HMO
CHA1-POS
CHA4-POS Open Access

Recommendation No. 14:

Cigna shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-102, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect a correct definition of who qualifies as a disabled dependent as required by Colorado insurance law. Within these sixty (60) days, Cigna shall also provide the Division with specimen copies of all revised policy forms reflecting a correct definition of a disabled dependent and the proposed date the forms will be put in use.

In the market conduct examination for the period January 1, 2005 through December 31, 2005, Cigna was cited for failure to correctly define a "disabled dependent". The violation resulted in Item #11 of Final Agency Order O-08-011 that indicated the Company was required to revise its forms to correctly reflect who qualifies as a disabled dependent as required by Colorado insurance law. Having been previously ordered to revise its forms in this manner, the Company knew or should have reasonably known that its continued use of such forms during the current examination period constituted a repeat violation of § 10-16-102, C.R.S., providing grounds for an increased penalty pursuant to § 10-1-205(3)(d), C.R.S.

RATES

Issue F1: Providing a premium discount to some groups at renewal that was not included in any rate filing or group contract.

Section 10-3-1104, C.R.S., Unfair methods of competition – unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> . . .
>
> (g) Rebates: Except as otherwise expressly provided by law, knowingly permitting, or offering to make, or making any contract of insurance or agreement as to such contract, *other than as plainly expressed in the insurance contract issued thereon, or paying, or allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract*, or any special favor or advantage in the dividends *or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract*; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or annuity or in connection therewith any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; [Emphasis added.]

Section 10-16-107, C.R.S., Rate regulation – rules - approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain, states in part:

> . . .
>
> (2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 *and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner*. [Emphasis added.]

Colorado Insurance Regulation 4-2-11, Rate Filing Submissions for Health Insurance, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), 10-16-109, and 10-18-105(2), C.R.S., states in part:

> . . .
>
> Section 4 Definitions
>
> . . .

R. "Rate" means, for purposes of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, and the insured's share of the carrier's claim settlement, operational and administrative expenses, and cost of capital. *This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract*.

S. "Rate filing," for purposes of this regulation, is a filing that *contains all of the items required in this regulation and Bulletin B-4.18* entitled "Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers;" and

. . .

2. For group products, the underlying rating factors and assumptions, *and support for changes in these factors and assumptions*. [Emphases added.]

Cigna was not in compliance with Colorado insurance law in that it was using a program in which concessions (discounts) were applied to group renewal rates in some instances when a group agreed to renew its coverage prior to its normal renewal date; this provision was not expressed in the group insurance contracts nor was it reflected in the rates filed with the Division of Insurance for use during the period of the examination. This program identified as, "early renewal incentive program", applied concessions to the rates for certain groups if they agreed to renew with Cigna prior to their normal renewal date, and committed to not taking the case out to bid with other carriers. Use of this program equates to use of a rebating process that had not been expressed in the insurance contract or included in Cigna's rate filings.

Recommendation No. 15:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-3-1104, and 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has either discontinued using the "early renewal incentive program" or included information concerning the program in its contracts and submitted a rate filing to the Division that includes a description of this program. Within these sixty (60) days, if applicable, Cigna shall also provide the Division with specimen copies of all revised contract forms and rate filings containing information concerning the "early renewal incentive program" and the proposed date the forms and rates will be put in use.

CLAIMS HANDLING

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents.* A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. [Emphasis added.]

. . .

(4)(a) Clean claims shall be paid, denied, or settled within *thirty calendar days after receipt* by the carrier if submitted electronically and within *forty-five calendar days after receipt* by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

Using ACL ™ software, the examiners randomly selected 100 claims from the population of 1,181 claims electronically received during the examination period that required more than thirty (30) calendar days from date of receipt to process. Cigna was not in compliance with Colorado insurance law in that fifty-five (55) of the 100 claims were determined to be clean claims that were not paid, denied or settled within the required thirty (30) days.

ELECTRONIC CLAIMS ADJUDICATED 30 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,181*	100	55	55%

*2 % of all electronic claims received

Using ACL ™ software, the examiners randomly selected 100 claims from the population of 111 claims received other than electronically during the examination period that required more than forty-five (45) calendar days from date of receipt to process. Cigna was not in compliance with Colorado insurance law in that sixty-three (63) of the 100 claims were determined to be clean claims that were not paid, denied or settled within the required forty-five (45) days.

NON-ELECTRONIC CLAIMS ADJUDICATED 45 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Percentage to Sample
111*	100	63	63%

*3 % of all non-electronic claims received

Using ACL ™ software, the examiners randomly selected 100 claims from the population of 483 claims received during the examination period that required more than ninety (90) calendar days from date of receipt to process. Cigna was not in compliance with Colorado insurance law in that forty-five (45) of the 100 claims, (none of which involved fraud), were paid, denied or settled within the required ninety (90) days.

CLAIMS ADJUDICATED 90 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Percentage to Sample
483*	100	45	45%

*0.9 % of all claims received

Recommendation No. 16:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event Cigna is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing that it is now in compliance.

Otherwise, Cigna shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay late payment penalties due on claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> . . .
>
> (4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> . . .
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.
>
> . . .
>
> *(5)(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim.* Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee. [Emphasis added.]

Cigna was not in compliance with Colorado insurance law in that, in some instances, the Company did not pay the late payment penalties that were due on claims not paid, or settled within the required ninety (90) days. When questioned as to the reason for non-payment of the penalties that were owed, Cigna responded: "The guidance was clearly included in the Standard Operating Procedure (SOP); however, not paying the late payment penalty in certain instances was an oversight by the Company. The Company has addressed the issue to ensure that the aforementioned oversight does not continue going forward".

Once this issue was brought to the Company's attention, the Company chose to issue late payment penalty checks during the examination. The examiners were furnished with documentation of the payments.

The examiners determined that twenty-five (25) of the 100 claims not paid, or settled within ninety (90) days did not include the required twenty percent (20%) penalty.

PAID CLAIMS ADJUDICATED BEYOND 90 DAYS FOR WHICH NO PENALTY WAS PAID

Population	Sample Size	Number of Exceptions	Total Error Rate
483*	100	25	25%

*(0.9 % of all claims received)

Recommendation No. 17:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event Cigna is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, Cigna shall be required; within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has established the necessary procedures to ensure that all late payment interest and penalties due on claims is correctly calculated and paid as required by Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to have initial denial of benefit letters or first level review adverse determinations signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits – internal review – rules, states in part:

> . . .
>
> (4) All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient *shall be signed by a licensed physician familiar with standards of care in Colorado*. . . . [Emphasis added.]

Colorado insurance law requires all written denials of requests for covered benefits as a result of the benefits not being medically necessary, appropriate, effective or efficient, to be signed by a licensed physician. Cigna provided four (4) First Level Appeals and two (2) Second Level Appeals of adverse determinations received during 2010. Two (2) of the initial letters of denial provided with these appeal files were signed by an individual on behalf of an MD, with the title of "Medical Director".

Denial Letters in Appeal Files Not Signed by a Licensed Physician

Population	Sample	Number of Exceptions	Total Error Rate
6	6	2	33%

A random sample of 100 files was chosen, using ACL™ software from a population of 199 adverse determinations involving utilization review requests received in 2010. A review of these files indicated that twelve (12) of the files contained denial letters that were not signed by a licensed physician.

Denial Letters in Sample of All Initial Decisions Involving Utilization Review Not Signed by a Licensed Physician

Population	Sample	Number of Exceptions	Total Error Rate
199	100	12	12%

Recommendation No. 18:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-113, C.R.S. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has implemented procedures to ensure that all written denials of benefits, on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient, are signed by a licensed physician familiar with standards of care in Colorado as required by Colorado insurance law.

Issue K2: Issue removed.

Issue K3: Failure, in some instances, to provide covered persons the twenty (20) day advance notice required for voluntary second level reviews. *(The examiners identified this as a repeat of prior issue K7 in the findings of the 2005 final examination report.)*

Colorado Insurance Regulation, 4-2-17, Prompt Investigation of Health Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-109, and 10-16-113, subsections (2) and (3)(b), C.R.S., states in part:

. . .

Section 11 Voluntary Second Level Review

. . .

G. A health carrier's procedures for conducting a voluntary second level review shall include the following:

1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. *The covered person shall be notified in writing at least twenty (20) days in advance of the review date.* The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. [Emphasis added.]

Cigna provided a population of two (2) Second Level Appeals received during 2010. These appeals of adverse determinations of First Level Appeals require at least twenty (20) days advance, written, notification of the scheduled review date. The notification letters advising of the review date for these two Second Level Appeal Files were not in compliance with Colorado insurance law in that they gave only ten (10) and seven (7) days advance notice as indicated below for each file.

Date of Notification Letter	Review Date
September 28, 2010	October 8, 2010
December 2, 2010	December 9, 2010

SECOND LEVEL APPEAL FILES RECEIVED IN 2010

Population	Sample	Number of Exceptions	Total Error Rate
2	2	2	100%

Recommendation No. 19:

Cigna shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event Cigna is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, Cigna shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has implemented procedures to ensure that notification in writing

to a covered person shall be at least twenty (20) days in advance of the review date for a voluntary second level review as required by Colorado insurance law.

In the market conduct examination for the period January 1, 2005 through December 31, 2005, Cigna was cited for failure, in some instances, to provide notice of voluntary second level review scheduling to covered persons at least twenty (20) days prior to the scheduled review date. The violation resulted in Item #27 of Final Agency Order O-08-011 that indicated the Company was required to revise its policies and procedures to ensure that covered persons are notified in writing at least twenty (20) days in advance of the second level review date as required by Colorado insurance law. Having been previously ordered provide notification in this manner, the Company knew or should have reasonably known that its continued use of such forms during the current examination period constituted a repeat violation of Colorado Insurance Regulation 4-2-17, providing grounds for an increased penalty pursuant to § 10-1-205(3)(d), C.R.S.

SUMMARY OF ISSUES AND RECOMMENDATIONS

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Issue E4: Failure of the Company's forms, in some instances, to reflect required minimum standards for handling appeals involving utilization review determinations.	4	36
Issue E5: Failure to include all required items on the form to be used by enrollees wishing to register written complaints.	5	37
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Issue E10: Failure of the Company's forms, in some instances, to correctly reflect the required coverage for inherited enzymatic disorders.	10	49
Issue E11: Failure of the Company's forms, in some instances, to provide accurate information regarding the responsibility to track member copayments and copayment maximums. *(The examiners identified this as a repeat of prior issue E1 in the findings of the 2005 final examination report.)*	11	51
Issue E12: Failure of the Company's forms, in some instances, to reflect correct information regarding the subscribers' option to continue coverage.	12	54
Issue E13: Failure of the Company's forms, in some instances, to reflect the required disclosure regarding specific counties with no participating providers.	13	55
Issue E14: Failure of the Company's forms, in some instances, to reflect a correct definition of a disabled dependent. *(This was part of prior issue E2 in the findings of the 2005 final examination report.)*	14	57
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Issue K3: Failure, in some instances, to provide covered persons the twenty (20) day advance notice required for voluntary second level reviews. *(The examiners identified this as a repeat of prior issue K7 in the findings of the 2005 final examination report.)*	19	69

Examination Report Submission

State Market Conduct Examiner

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Submit this report on this 8th Day of November, 2012 to:

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